SACRAMENTO STATE

California State University, Sacramento
Student Health & Counseling Services
6000 J Street • The WELL • Sacramento, CA 95819-6045
T (916) 27-6461 • F (916) 278-7359 • www.csus.edu/shcs

MINOR CONSENT FOR MEDICAL SERVICES

(For use with Students 17 years of age and younger, as applicable)

I hereby authorize Sacramento State Student Health & Counseling Services to provide, at the request of my Minor son/daughter _____ Medical services, as needed. I further authorize any necessary emergency care in the event that I cannot be reached to give direct permission.

_____ _____
Parent/Guardian Signature **Date**

**** PLEASE PRINT ****

Minor's Name: _____

Date of Birth: _____ Student ID #: _____

Parent/Guardian: _____

Address/State/Zip: _____

Phone Number: _____

Emergency Contact: _____

Phone Number: _____ Relationship: _____

List of Medical Conditions: _____

Allergies: _____

FOR OFFICE USE ONLY

Telephone Consent

Parent/Guardian consent given: ☐ Yes ☐ No Date/Time of Consent: _____

Method of *Verification* of Identity: (Check all that apply)

☐ Call at workplace ☐ Parent/Guardian CDL: _____

☐ Gave student's date of birth as: _____

No minor consent required for Reproductive Health Services

_____ _____
Staff Signature/Title Date/Time